Date: _____

Charles M. Middleton, DDS
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Middleton Family Dentistry

Family. It's the people you rely on. At Middleton Family Dentistry, we build relationships with our patients based on trust and comfort. Our friendly team will exceed your expectations and make you feel right at home.

Thank you for choosing us for your dental needs. What brought you to Middleton Family Dentistry?

❑ Website ❑ Google/Internet Reviews ❑ Facebook ❑ Insurance ❑ Referral _____ ❑ Other _____

You have the responsibility to provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.

Patient Information Check appropriate box: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Minor *(under 18 years old)*

First Name: _____ Middle Initial: _____ Last Name: _____

Birthdate (mm/dd/yyyy): _____ Email: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Gender: ❑ Male ❑ Female ❑ Other _____ Social Security #: _____

Emergency Contact: _____ Relation: _____ Phone#: _____

Previous Dentist (new patients only): _____ Date of Last Exam: _____

Medical History

	Yes	No
1. Are you pregnant or currently nursing?	☐	☐
2. Have you been hospitalized for a surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medications, including non-prescription medicine?	☐	☐
If yes, please explain _____		
4. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?	☐	☐
5. Do you use tobacco products and/or vaping devices?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you allergic to or have you had any reactions to any of the following?		
Local anesthetics (e.g., Novocaine)	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Hydrocodone/Codeine	☐	☐
Aspirin	☐	☐
Metals (e.g., nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐
_____		
8. Have you traveled outside of the country in the past 21 days?	☐	☐

	Yes	No
9. Do you have or have you had any of the following?		
Joint Replacement or Implant	☐	☐
High/Low Blood Pressure	☐	☐
Heart Disease/Attack	☐	☐
Cardiac Pacemaker	☐	☐
Valve replacement/Endocarditis	☐	☐
Mitral Valve Prolapse	☐	☐
Cancer/Leukemia/Radiation Therapy	☐	☐
Stroke	☐	☐
Arthritis	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Infection	☐	☐
Aids or HIV Infection	☐	☐
Stomach Troubles/Ulcers	☐	☐
Tuberculosis	☐	☐
Glaucoma	☐	☐
Asthma/COPD/Emphysema	☐	☐
Sleep Apnea	☐	☐
Fainting/Seizures/Epilepsy	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
Thyroid Problem (hypo/hyper)	☐	☐

10. Are you currently taking or have you taken any of the following medications for osteoporosis?

☐ Actonel (Risedronate) ☐ Aredia (Pamidronate)
☐ Zometa (Zoledronic) ☐ Fosamax Plus D
☐ Bonefos (Clodronate) ☐ Skelid (Tiludronate)
☐ Didronel (Etidronate) ☐ Boniva (Ibandronate)
☐ None

ACKNOWLEDGEMENT OF HIPAA

Please check one. I have read a copy of Middleton Family Dentistry's HIPAA Privacy Notice.

☐ I **allow** the following person(s) to obtain my information protected by the HIPAA Privacy Notice.

_____ and _____

The person(s) above may have access to my treatment, billing, and appointment information.

☐ I **do not allow** anyone outside of Middleton Family Dentistry to have access to this information.

- It is the patient's responsibility to request to update their HIPAA preferences allowing or not allowing other people outside of Middleton Family Dentistry to have access to their information.

APPOINTMENT POLICIES

- We recommend that you come 10-15 minutes before your scheduled appointment to allow time for paperwork.
- In our office, we value the time appointed for all of our patients. If you are unable to make it to your appointment on time, please call, and we may be able to find a later appointment for you on the same day if the schedule permits.
- As a courtesy to the practice and other patients, please give us at least 2 business days notice if you need to cancel or reschedule, so that we may offer that appointment time to another patient. We reserve the right to charge a $50.00 administrative fee for not showing up to an appointment, or for appointments canceled without 2 business days notice.

By signing below, I have read and understand the information presented, and all my questions have been answered.

Patient name: _____ Date: _____

Signature: _____